

**Virginia Cancer Registry Reporting Form**  
**P.O. Box 2448, Room 114 - Richmond, VA 23218**

Facility Name: \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_

Number of Previous Primary Cancers \_\_\_\_\_ Date Admitted \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address (at DX) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City/Co. of Residence \_\_\_\_\_

Please indicate with a check whether residence is in a county \_\_\_\_ or independent city \_\_\_\_

**Race**

- |                      |                             |
|----------------------|-----------------------------|
| 01 = White           | 20 = Micronesian, NOS*      |
| 02 = Black           | 21 = Chamorroan             |
| 03 = American Indian | 22 = Guamanian, NOS         |
| Aleutian, Eskimo     | 25 = Polynesian, NOS        |
| 04 = Chinese         | 26 = Tahitian               |
| 05 = Japanese        | 27 = Samoan                 |
| 06 = Filipino        | 28 = Tongan                 |
| 07 = Hawaiian        | 30 = Melanesian, NOS        |
| 08 = Korean          | 31 = Fiji Islander          |
| 09 = Asian Indian,   | 32 = New Guinean, NOS       |
| Pakistani            | 96 = Other Asian (including |
| 10 = Vietnamese      | Asian, NOS and              |
| 11 = Laotian         | Oriental, NOS)              |
| 12 = Hmong           | 97 = Pacific Islander, NOS  |
| 13 = Kampuchean      | 98 = Other                  |
| 14 = Thai            | 99 = Unknown                |

**Ethnic Type**

- |                  |                        |
|------------------|------------------------|
| 0 = Non Spanish  | 4 = South American     |
| 1 = Mexican      | 5 = Other Spanish      |
| 2 = Puerto Rican | 6 = Spanish, NOS       |
| 3 = Cuban        | 9 = Unknown if Spanish |

**Sex**

- |            |                 |
|------------|-----------------|
| 1 = Male   | 4 = Transsexual |
| 2 = Female | 9 = Not stated  |
| 3 = Other  |                 |

**Age at Diagnosis**

**Date of Birth**

\_\_\_\_\_  
M M D D Y Y Y Y

**Usual Occupation**

**Company or Industry**

**Marital Status at Dx**

- |                                |              |
|--------------------------------|--------------|
| 1 = Single (never married)     | 4 = Divorced |
| 2 = Married (incl. common law) | 5 = Widowed  |
| 3 = Separated                  | 9 = Unknown  |

**Date of Initial Diagnosis**

\_\_\_\_\_  
M M D D Y Y Y Y

Revised 1/98

**Primary Site of Cancer**

**Paired Organ**

- |                      |                                |
|----------------------|--------------------------------|
| 0 = not paired organ | 3 = one side, NOS              |
| 1 = right side       | 4 = both sides, single primary |
| 2 = left side        | 9 = unknown                    |

**Diagnostic Confirmation**

- 1 = positive histology  
2 = positive exfoliative cytology - no positive histology  
4 = positive microscopic confirmation - method not specified  
5 = positive laboratory test or marker study  
6 = direct visualization without microscopic confirmation  
7 = radiography and other imaging techniques without microscopic confirmation  
8 = clinical diagnosis only (other than 5, 6 or 7)  
9 = unknown whether or not microscopically confirmed

**Histology**

**Behavior Code**

- 0 = Benign  
1 = Uncertain whether benign or malignant, Borderline malignancy, Low malignant potential  
2 = Carcinoma in-situ, Intraepithelial, Noninfiltrating, Noninvasive  
3 = Malignant, primary site

**Grade**

- 1 = Grade I - Well differentiated, Differentiated, NOS  
2 = Grade II - Moderately differentiated, Moderately well differentiated, Intermediate differentiation  
3 = Grade III - Poorly differentiated  
4 = Grade IV - Undifferentiated Anaplastic  
9 = Grade or differentiation not determined, not stated or not applicable

**Summary Stage**

- 0 = Carcinoma in-situ  
1 = Localized  
2 = Regional, direct extension only  
3 = Regional, nodes only  
4 = Regional, direct extension & nodes  
5 = Regional, NOS  
7 = Distant  
9 = Unstaged, unknown or unspecified

**Treatment (type)**

Surgery Date \_\_\_\_\_

Type \_\_\_\_\_

Radiation Date \_\_\_\_\_

Type \_\_\_\_\_

Chemotherapy Date \_\_\_\_\_

Type \_\_\_\_\_

Other Treatments (specify date and type for each)

**Date of Last Contact or Death**

\_\_\_\_\_  
M M D D Y Y Y Y

**Status of Patient**

- 0 = Dead  
1 = Alive

**Tobacco History**

Y N

**Alcohol History**

Y N

**Vietnam Veteran**

Y N

**Dioxin Exposure**

Y N

**Hospital Referred from**

**Hospital Referred to**

**Person Completing Form:**

Date \_\_\_\_\_

\*NOS - Not Otherwise Specified